		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034694

Facility Name: Oakbrook Healthcare Centre

Address: 2013 Midwest Road (Number) Oak Brook (City) 60523 (Zip Code)

County: DuPage

Telephone Number: (630) 495-0220 **Fax #** (630) 495-9150

IDPA ID Number: #36-3601135-001

Date of Initial License for Current Owners: 09/07/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-01 to 31-Dec-01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 28-March-2002 (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 1-May-2000

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	126	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,220	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	154	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,581	2,792	4,184	17,557	8
9	SNF/PED					9
10	ICF	18,708	14,224		32,932	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,289	17,016	4,184	50,489	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.67%

D. How many bed-hold days during this year were paid by Public Aid?
170 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started September 7, 1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date October 26, 1988 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 126 and days of care provided 4,043

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	249,840	84,889	11,506	346,235		346,235		346,235			1
2	Food Purchase		181,286		181,286	(8,355)	172,931	(585)	172,346			2
3	Housekeeping	318,534	54,089	5,746	378,369		378,369		378,369			3
4	Laundry	67,664	35,068	3,537	106,269		106,269		106,269			4
5	Heat and Other Utilities			166,557	166,557		166,557		166,557			5
6	Maintenance	52,500	37,390	88,817	178,707		178,707	2,364	181,071			6
7	Other (specify):*											7
8	**TOTAL General Services**	688,538	392,722	276,163	1,357,423	(8,355)	1,349,068	1,779	1,350,847			8
	B. Health Care and Programs											
9	Medical Director			18,050	18,050		18,050		18,050			9
10	Nursing and Medical Records	2,013,106	170,581	310,754	2,494,441		2,494,441		2,494,441			10
10a	Therapy			62,492	62,492		62,492		62,492			10a
11	Activities	120,256	17,278	2,436	139,970		139,970		139,970			11
12	Social Services	70,862		4,253	75,115		75,115		75,115			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,204,224	187,859	397,985	2,790,068		2,790,068		2,790,068			16
	C. General Administration											
17	Administrative	131,201		172,800	304,001		304,001	(139,509)	164,492			17
18	Directors Fees											18
19	Professional Services			14,467	14,467		14,467	21,344	35,811			19
20	Dues, Fees, Subscriptions & Promotions			30,778	30,778		30,778	(13,520)	17,258			20
21	Clerical & General Office Expenses	90,205	56,726	75,127	222,058		222,058	59,806	281,864			21
22	Employee Benefits & Payroll Taxes			400,188	400,188	8,355	408,543	22,234	430,777			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,317	6,317		6,317	190	6,507			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			56,499	56,499		56,499	39,844	96,343			26
27	Other (specify):*							11,887	11,887			27
28	**TOTAL General Administration**	221,406	56,726	756,176	1,034,308	8,355	1,042,663	2,276	1,044,939			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,114,168	637,307	1,430,324	5,181,799		5,181,799	4,055	5,185,854			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Oakbrook Healthcare Centre #0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			80,215	80,215		80,215	188,251	268,466			30
31	Amortization of Pre-Op. & Org.							6,699	6,699			31
32	Interest			288,203	288,203		288,203	244,020	532,223			32
33	Real Estate Taxes			60,818	60,818		60,818		60,818			33
34	Rent-Facility & Grounds			1,802,644	1,802,644		1,802,644	(1,800,000)	2,644			34
35	Rent-Equipment & Vehicles			4,733	4,733		4,733		4,733			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,236,613	2,236,613		2,236,613	(1,361,030)	875,583			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		168,408	92,834	261,242		261,242		261,242			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,410	85,410		85,410		85,410			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		168,408	178,244	346,652		346,652		346,652			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,114,168	805,715	3,845,181	7,765,064		7,765,064	(1,356,975)	6,408,089			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	35,686	30		9
10	Interest and Other Investment Income	(21,741)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(585)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,687)	21		24
25	Fund Raising, Advertising and Promotional	(18,531)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(854)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (9,712)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,347,263)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,347,263)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,356,975)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Oakbrook Healthcare Centre

ID# 0034694

Report Period Beginning: 1-Jan-01

Ending: 31-Dec-01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(585)	0	0	0	0	0	0	0	0	0	0	(585)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	2,364	0	0	0	0	0	0	0	0	0	2,364	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(585)	2,364	0	0	0	0	0	0	0	0	0	1,779	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(139,509)	0	0	0	0	0	0	0	0	0	(139,509)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,489	0	0	0	0	0	0	0	0	0	10,489	19
20	Fees, Subscriptions & Promotions	(19,385)	5,796	0	0	0	0	0	0	0	0	0	(13,589)	20
21	Clerical & General Office Expenses	(3,687)	63,493	0	0	0	0	0	0	0	0	0	59,806	21
22	Employee Benefits & Payroll Taxes	0	22,234	0	0	0	0	0	0	0	0	0	22,234	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	190	0	0	0	0	0	0	0	0	0	190	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	263	0	0	0	0	0	0	0	0	0	263	26
27	Other (specify):*	0	11,887	0	0	0	0	0	0	0	0	0	11,887	27
28	**TOTAL General Administration**	(23,072)	(25,157)	0	0	0	0	0	0	0	0	0	(48,229)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,657)	(22,793)	0	0	0	0	0	0	0	0	0	(46,450)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 **Report Period Beginning:** 1-Jan-01 **Ending:** 31-Dec-01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	35,686	764	0	0	0	0	0	0	0	0	0	36,450	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(21,741)	(227,236)	0	0	0	0	0	0	0	0	0	(248,977)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	13,945	(226,472)	0	0	0	0	0	0	0	0	0	(212,527)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(9,712)	(249,265)	0	0	0	0	0	0	0	0	0	(258,977)	45

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Salary-Cynthia and Laurence	$	Lancaster, Ltd.	100.00%	$ 18,692	$ 18,692	1
2	V		27	P/R Taxes		Lancaster, Ltd.	100.00%	11,887	11,887	2
3	V		17	Management Fee Income	172,800	Lancaster, Ltd.	100.00%		(172,800)	3
4	V		19	Professional Services		Lancaster, Ltd.	100.00%	10,489	10,489	4
5	V		21	Office Expenses		Lancaster, Ltd.	100.00%	63,493	63,493	5
6	V		22	Employee Benefits		Lancaster, Ltd.	100.00%	22,234	22,234	6
7	V		24	Education and Seminars		Lancaster, Ltd.	100.00%	190	190	7
8	V		17	Administrative Consultant		Lancaster, Ltd.	100.00%	14,599	14,599	8
9	V		20	Fees and Marketing		Lancaster, Ltd.	100.00%	5,796	5,796	9
10	V		32	Interest	288,203	Lancaster, Ltd.	100.00%	60,967	(227,236)	10
11	V		30	Depreciation		Lancaster, Ltd.	100.00%	764	764	11
12	V		6	Maintenance		Lancaster, Ltd.	100.00%	2,364	2,364	12
13	V		26	Professional Liability Ins.		Lancaster, Ltd.	100.00%	263	263	13
14	Total				$ 461,003			$ 211,738	$ * (249,265)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Cynthia Chow	Officer	Administrative	33.34%	See Attached	2	3.0%	Lancaster	$ 3,692	17-7	1
2	Laurence Zung	Officer	Administrative	33.33%	See Attached	2	4.17%	Lancaster	15,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 18,692		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, Il. 60630
Phone Number: (773)478-3699
Fax Number: (773)478-1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Cynthia Chow	Hours Worked	65	7	$ 120,000	$ 120,000	2	$ 3,692	1
2	27	Cynthia Chow	Hours Worked	65	7	6,835	0	2	210	2
3	17	Laurence Zung	Hours Worked	48	7	360,000	360,000	2	15,000	3
4	27	Laurence Zung	Hours Worked	48	7	10,315	0	2	430	4
5										5
6										6
7	19	Professional Services	Management Fees	1,697,900	7	103,061	0	172,800	10,489	7
8	21	Office Expenses	Management Fees	1,697,900	7	27,792	0	172,800	2,828	8
9	22	Employee Benefits	Management Fees	1,697,900	7	218,469	0	172,800	22,234	9
10	24	Education and Seminars	Management Fees	1,697,900	7	1,868	0	172,800	190	10
11	17	Administrative Consultant	Management Fees	1,697,900	7	143,451	0	172,800	14,599	11
12	20	Marketing	Management Fees	1,697,900	7	54,625	0	172,800	5,559	12
13	32	Interest	Management Fees	1,697,900	7	109,907	0	172,800	11,186	13
14	30	Depreciation	Management Fees	1,697,900	7	7,511	0	172,800	764	14
15	26	Professional Liability Ins.	Management Fees	1,697,900	7	2,588	0	172,800	263	15
16	20	Licenses and Fees	Management Fees	1,697,900	7	2,330	0	172,800	237	16
17	6	Maintenance	Management Fees	1,697,900	7	23,228	0	172,800	2,364	17
18	21	Salary-Clerical	Management Fees	1,697,900	7	596,087	596,087	172,800	60,665	18
19	27	P/R Taxes-Clerical	Management Fees	1,697,900	7	110,511	0	172,800	11,247	19
20										20
21										21
22	32	Direct Interest		1		49,781	0	1	49,781	22
23										23
24										24
25	TOTALS					$ 1,948,359	$ 1,076,087		$ 211,738	25

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Cambridge Reality Capital		X	Mortgage	$49,956.72	11/01/98	$ 8,152,700	$ 7,950,242	11/30/34	6.63%	$ 528,501	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lancaster, Ltd.	X		Working capital							11,186	6
7												7
8												8
9	TOTAL Facility Related				$49,956.72		$ 8,152,700	$ 7,950,242			$ 539,687	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,152,700	$ 7,950,242			$ 539,687	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Oakbrook Healthcare Centre **#** 0034694 **Report Period Beginning:** 1-Jan-01 **Ending:** 31-Dec-01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	58,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	58,818	2
3. Under or (over) accrual (line 2 minus line 1).	$	818	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	60,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	60,818	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	54,954	8
	1997	56,070	9
	1998	56,523	10
	1999	57,645	11
	2000	58,818	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oakbrook Healthcare Centre COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0034694

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773)604-4416 FAX #: (773)478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-22-303-035	Long-Term Healthcare	$ 58,817.66	$ 58,817.66
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 58,817.66	$ 58,817.66

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 234,464
2. Number of Years Over Which it is Being Amortized: 35
3. Current Period Amortization: 6,699
4. Dates Incurred: 26-Oct-98

Nature of Costs: Pre-Operating Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Care Facility		1998	$ 830,000	1
2					2
3	TOTALS			$ 830,000	3

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	154				$ 3,586,000	$ 91,949	40	$ 91,949	$	$ 325,653	4
5	144		1992	1994	1,863,459	59,157	35	59,157		507,275	5
6	10		1994		25,000	641	35	641		5,360	6
7											7
8											8
	Improvement Type**										
9	Various			1988	8,828	286	20	286		6,932	9
10	Various			1989	92,298	3,426	20	3,426		58,272	10
11	Various			1990	24,448	595	20	595		12,564	11
12	Various			1991	2,212	70	15	70		884	12
13	Various			1992	1,275,149	40,483	20	40,483		534,958	13
14	Various			1993	289,021	6,465	15	6,465		110,955	14
15	Various			1994	10,459	317	15	317		3,143	15
16	Various			1995	52,918	473	15	473		10,617	16
17	Room #112 remodeling			1996	2,285	59	15	59		629	17
18	Nurses' call station			1996	10,545	270	15	270		2,554	18
19	Ceramic tiled bathroom and tub room			1996	15,362	394	20	394		3,786	19
20	Rehab room			1997	31,848	817	15	817		7,052	20
21	Fire doors			1997	3,013	77	15	77		668	21
22	Physical Therapy room			1997	6,749	173	15	173		1,493	22
23	12 bathrooms vented			1997	8,670	222	15	222		1,813	23
24	Roof improvements			1997	7,150	183	15	183		1,436	24
25	Excelon vinyl tiles - 1st floor			1997	15,600	400	15	400		2,935	25
26	Excelon vinyl tiles - 1st floor			1998	6,204	159	15	159		1,089	26
27	New foof			1998	3,850	99	15	99		334	27
28	Custom cabinets			1998	3,285	84	15	84		284	28
29	Fire alarm switch			1998	6,996	179	15	179		559	29
30	3 shower rooms rehab			1999	15,560	399	15	399		1,114	30
31	Hot water heaer			1999	7,269	186	15	186		442	31
32	Parking lot asphalt			1999	28,900	741	15	741		1,883	32
33	Rehab resident rooms			1999	17,825	457	15	457		1,085	33
34	Aquarium			2001	4,441	81	15	81		81	34
35	Picture window			2001	14,403	231	15	231		231	35
36	Wander guard system			2001	17,385	2,484	15	2,484		2,484	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpet - bookkeeping & lounge	2001	$ 2,715	$ 44	15	$ 44	$	$ 44	37
38	Vinyl tiles hallway	2001	9,815	53	15	53		53	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,469,662	$ 211,654		$ 211,654	$	$ 1,608,662	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 495,306	$ 14,744	$ 51,156	$ 36,412	10	$ 331,126	71
72	Current Year Purchases	32,405	5,656	5,656		10	5,656	72
73	Fully Depreciated Assets	313,409	726		(726)		313,409	73
74								74
75	TOTALS	$ 841,120	$ 21,126	$ 56,812	$ 35,686		$ 650,191	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,140,782	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 232,780	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 268,466	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 35,686	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,258,853	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ***N/A - Related Party Lease***

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		***Off-site Public Storage Space***			2,644			5
6								6
7	TOTAL				$ 2,644 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 4,733 Description: $394.42 / month for Toshiba Copier for Landen Copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 24,089	$		$ 24,089	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,650			3,650	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			25,842			25,842	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				104,609		104,609	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Inhalation Therapy Other (specify): Med Sup/Sp Bed Rent	39-3 39-2				39,253	63,799		39,253 63,799	13
14	TOTAL			$		$ 92,834	$ 168,408		$ 261,242	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 **Report Period Beginning:** 1-Jan-01 **Ending:** 31-Dec-01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (57,302)	$ 14,065	1
2	Cash-Patient Deposits	43,635	43,635	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,175,983	1,175,983	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,521	1,521	6
7	Other Prepaid Expenses	32,115	336,923	7
8	Accounts Receivable (owners or related parties)	240,706	240,706	8
9	Other(specify): Employee Advances	4,043	4,043	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,440,701	$ 1,816,876	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		830,000	13
14	Buildings, at Historical Cost		3,586,000	14
15	Leasehold Improvements, at Historical Cost	1,946,813	3,835,272	15
16	Equipment, at Historical Cost	700,427	821,082	16
17	Accumulated Depreciation (book methods)	(1,189,343)	(2,195,296)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		234,464	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(21,214)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,457,897	$ 7,090,308	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,898,598	$ 8,907,184	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 94,384	$ 94,384	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,817	35,817	28
29	Short-Term Notes Payable	152,731	227,759	29
30	Accrued Salaries Payable	74,855	74,855	30
31	Accrued Taxes Payable (excluding real estate taxes)	41,600	41,600	31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,000	60,000	32
33	Accrued Interest Payable		43,892	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 459,387	$ 578,307	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,400,000	2,400,000	39
40	Mortgage Payable		7,875,214	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,400,000	$ 10,275,214	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,859,387	$ 10,853,521	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 39,211	$ (1,946,337)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,898,598	$ 8,907,184	48

***(See instructions.)**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,250,971)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,250,971)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	984,445	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,679,811)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (695,366)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,946,337)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,905,415	1
2	Discounts and Allowances for all Levels	(729,566)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,175,849	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	265,254	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 265,254	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	5,607	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	105,955	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,121	19
20	Radiology and X-Ray	3,586	20
21	Other Medical Services	56,944	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 186,213	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	21,741	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 21,741	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	2,454	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,454	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,651,511	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,357,423	31
32	Health Care	2,790,068	32
33	General Administration	1,034,308	33
	B. Capital Expense		
34	Ownership	2,236,613	34
	C. Ancillary Expense		
35	Special Cost Centers	261,242	35
36	Provider Participation Fee	85,410	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,765,064	40
41	**Income before Income Taxes (line 30 minus line 40)****	(113,553)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (113,553)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.** *Tax return not compl

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,049	2,341	$ 84,204	$ 35.97	1
2	Assistant Director of Nursing	1,977	2,222	68,330	30.75	2
3	Registered Nurses	29,850	32,124	736,217	22.92	3
4	Licensed Practical Nurses	11,554	12,309	226,641	18.41	4
5	Nurse Aides & Orderlies	72,519	77,434	869,198	11.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,025	2,090	31,580	15.11	9
10	Activity Assistants	10,010	10,536	88,676	8.42	10
11	Social Service Workers	4,229	4,735	70,862	14.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,366	27,816	249,840	8.98	15
16	Dishwashers					16
17	Maintenance Workers	4,142	4,581	52,500	11.46	17
18	Housekeepers	34,914	38,491	318,534	8.28	18
19	Laundry	8,041	8,721	67,664	7.76	19
20	Administrator	2,049	2,277	86,780	38.11	20
21	Assistant Administrator	1,873	2,142	44,421	20.74	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,009	7,412	90,205	12.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,952	2,176	28,516	13.10	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	219,559	237,407	$ 3,114,168 *	$ 13.12	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	288	$ 11,506	1-3	35
36	Medical Director	451	18,050	9-3	36
37	Medical Records Consultant	103	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	71	1,240	10-3	39
40	Physical Therapy Consultant	1,219	62,492	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	62	2,436	11-3	44
45	Social Service Consultant	111	4,253	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,305	$ 104,009		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,337	$ 72,133	10-3	50
51	Licensed Practical Nurses	321	7,030	10-3	51
52	Nurse Aides	7,358	226,319	10-3	52
53	TOTAL (lines 50 - 52)	10,016	$ 305,482		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joanne Bedrosian	Administrator	N/A	$ 86,780
Rose Rivera	Asst. Adm	N/A	44,421
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 131,201

B. Administrative - Other

Description	Amount
Management Fees - Lancaster, Ltd.	$ 172,800
TOTAL (agree to Schedule V, line 17, col. 3)	$ 172,800
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems	Data Processing	$ 5,892
Power Software Development	Data Processing	3,273
Sanders & Associates	Legal	80
Lasko & Kocol	Legal	865
Joseph Panaese	Legal	712
Frost Ruttenberg & Rothblatt	Accounting	1,395
Richard Peelo	Accounting	2,250
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 14,467

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,787
Unemployment Compensation Insurance	18,214
FICA Taxes	234,254
Employee Health Insurance	98,397
Employee Meals	8,355
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan Contribution	9,616
Uniforms	2,664
Employment Fees	6,256
Lancaster Allocation	22,234
TOTAL (agree to Schedule V, line 22, col.8)	$ 430,777

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	948
Health Care Worker Background Check	
(Indicate # of checks performed 222)	2,775
Promotional Advertising	19,385
Dues & Subscriptions	3,678
Licenses and Fees	3,792
Lancaster Allocation	5,796
OakBrook Associates	69
Less: Public Relations Expense	( )
Non-allowable advertising	(18,531)
Yellow page advertising	(854)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,258

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 720
In-State Travel	236
Seminar Expense	5,361
Lancaster Allocation	190
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,507

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-01 Ending: 31-Dec-01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Oakbrook Healthcare Centre **#** 0034694 **Report Period Beginning:** 1-Jan-01 **Ending:** 31-Dec-01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **28,138** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **85,410**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **8,355** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.